MARKET CONDUCT EXAMINATION REPORT
AS OF DECEMBER 31, 2004

Rocky Mountain Health Maintenance Organization, Inc.
2775 Crossroads Blvd.
Grand Junction, Colorado 81506

NAIC Group Code 1184
NAIC Company Code 95482

EXAMINATION PERFORMED BY
DIVISION OF INSURANCE STAFF
COLORADO DEPARTMENT OF REGULATORY AGENCIES
STATE OF COLORADO

Rocky Mountain Health Maintenance Organization, Inc.
2775 Crossroads Blvd.
Grand Junction, CO 81506

LIMITED MARKET CONDUCT EXAMINATION REPORT as of December 31, 2004

Examination Performed by
Jeffory A. Olson, CIE, FLMI, AIRC, ALHC
John E. Bell
David M. Tucker, AIE, FLMI, ACS
Amy N. Gabert
Paula M. Sisneros, AIS

State Market Conduct Examiners

March 24, 2006

The Honorable David Rivera
Commissioner of Insurance
State of Colorado
1560 Broadway, Suite 850
Denver, Colorado 80202

Commissioner:

This limited market conduct examination of Rocky Mountain Health Maintenance Organization, Inc. (the Company) was conducted pursuant to Section 10-16-416, Colorado Revised Statutes, which authorizes the Insurance Commissioner to examine health maintenance organizations. We examined the Company's records at its office located at 2775 Crossroads Blvd, Grand Junction, Colorado 81506 and at the Colorado Division of Insurance offices at 1560 Broadway, Denver, Colorado, 80202. The market conduct examination covered the period from January 1, 2004, through December 31, 2004.

The following market conduct examiners respectfully submit the results of the examination.

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC

John E. Bell

David M. Tucker, AIE, FLMI, ACS

Amy N. Gabert

Paula M. Sisneros, AIS

MARKET CONDUCT
EXAMINATION REPORT
OF
ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION, INC.

TABLE OF CONTENTS

COMPANY PROFILE

Rocky Mountain HMO is an independent, non-profit, IPA-model health maintenance organization, which became licensed and began operation in Grand Junction (Mesa County) Colorado on June 24, 1974.

The HMO Act of 1973 established federal regulations for health maintenance organizations. In 1975, Rocky Mountain HMO became the seventh HMO in the nation to be federally qualified.

HISTORY

Rocky Mountain HMO was originally sponsored by the Medical Society of Mesa County which submitted a feasibility grant approved and awarded by the Department of Health, Education and Welfare in 1974. Working with local business leaders, healthcare planners and the medical community, the founders of Rocky Mountain HMO envisioned a cooperative that would assure a broad cross-section of Colorado citizens' access to quality healthcare at affordable rates.

In Western Colorado, the plan's founding territory, more than 90 percent of the physicians in most service areas participate with Rocky Mountain HMO. Nearly every hospital in the Western Slope service area participates. Statewide, Rocky Mountain HMO contracts with approximately 5,000 primary care and specialty physicians and 240 hospitals, rehabilitation centers, and skilled nursing facilities.

Rocky Mountain HMO provides medical benefit plans to more than 87,000 members. Through its family of health plans, Rocky Mountain HMO serves a broad cross-section of Coloradoans, including commercial groups, Medicare and Medicaid eligible persons, and children who receive care under the state's Child Health Plan Plus program.

ROCKY MOUNTAIN HMO MEMBERSHIP CATEGORIES

Commercial Plans

Commercial plans are the largest line of business, with enrollment accounting for 58 percent of Rocky Mountain HMO membership. Rocky Mountain HMO markets a variety of benefit plans with varying levels of coverage and flexibility. Although Rocky Mountain HMO provides coverage for many of the largest groups in the state, the majority of its group business consists of small to medium-sized Colorado-based employers.

Medicare Plans

Rocky Mountain HMO offers Medicare plans to Medicare beneficiaries through a cost contract with the federal Centers for Medicare & Medicaid Services (CMS). Approximately 22,000 Medicare members are enrolled with Rocky Mountain HMO. An additional 1200 members have a combination of Medicare and Medicaid plans.

Medicaid Program

Rocky Mountain HMO's contract with Colorado Medicaid gives the indigent access to an almost identical network of healthcare providers as the health plan's commercial members.

Early on, Rocky Mountain HMO elected to address the needs of all segments of its service area, including the indigent. Today, approximately 14,000 Colorado Medicaid recipients in 3 counties, Mesa, Montrose and Delta, are enrolled.

Child Health Plan Plus

Child Health Plan Plus (CHP+) is the state's low-cost program for children who do not qualify for Medicaid and are not covered by other insurance. As part of the CHP+ program in Delta, Mesa and Montrose counties, Rocky Mountain HMO covers approximately 2,600 children who would otherwise be left out of the healthcare delivery system.

ROCKY MOUNTAIN HMO FINANCIAL STABILITY

As of December 2004, the organization's reserves were approximately $50 million on 2004 revenues of approximately $206 million.

OPERATIONS

Rocky Mountain HMO operates only in Colorado. The company is certified to operate in all counties except Baca and Gunnison counties in the state of Colorado and its headquarters is located in Grand Junction, Colorado. Rocky Mountain HMO was created to provide local, community based care. Company branch offices are located throughout Colorado including Denver, Pueblo and Durango. Accounting records are maintained in the corporate office in Grand Junction, Colorado.

Rocky Mountain HMO provides health care benefits to large and small employer groups, Medicare and Medicaid recipients and to children enrolled in the CHP+ program. The company contracts with individual physicians, physician groups and physician practice associations, hospitals and other health care providers to provide health care services to its members. The payment methods used for payment of physicians and other health care providers includes negotiated fee for service rates, capitation rates, case rates and per diem rates. Rocky Mountain HMO contracts with over 5,000 physicians and providers statewide.

Rocky Mountain HMO operates under the trade name Rocky Mountain Health Plans. The NAIC Group code for Rocky Mountain HMO is 1184 and the NAIC company number is 95482.

ORGANIZATION STRUCTURE

Rocky Mountain HMO is a federal 501(c)(4) tax-exempt organization and a Colorado nonprofit corporation. Rocky Mountain HMO is federally qualified and has a certificate of authority from the Colorado Division of Insurance to operate as a health maintenance organization. Rocky Mountain HMO began operations as a health maintenance organization in 1974. A community Board of Directors directs Rocky Mountain HMO operations.

Rocky Mountain HMO is the sole member of Rocky Mountain HealthCare Options, Inc. (RMHCO), a Nonprofit Hospital, Medical-Surgical Health Service Corporation and owns 100% of the stock in CNIC Health Solutions (CNIC), a self-funded employer group administrator.

<u>Service Area</u>

The company is certified to operate in all counties except Baca and Gunnison counties in the state of Colorado and its headquarters is located in Grand Junction, Colorado.

Individual Enrollment As of 12-31-04**:	1,362
Small Group Enrollment As of 12-31-04**:	28,442
Large Group Enrollment As of 12-31-04**:	19,843
Individual Written Premium as of 12-31-04**:	$8,522,752
Small Group Written Premium as of 12-31-04**:	$88,629,479
Large Group Written Premium as of 12-31-04**:	$66,086,831
Market Share (all Colorado HMO's):	7.04%

** As provided by the Company.

PURPOSE AND SCOPE

State market conduct examiners with the Colorado Division of Insurance (DOI), in accordance with Colorado Insurance Law, Sections 10-1-201, 10-1-203, 10-1-204 and specifically 10-16-416, C.R.S., that empowers the Commissioner to require any company, entity, or new applicant to be examined, reviewed certain business practices of Rocky Mountain Health Maintenance Organization, Inc. The findings in this report, including all work products developed in producing it, are the sole property of the Colorado Division of Insurance.

The purpose of the limited examination was to determine the Company's compliance with Colorado insurance law and with generally accepted operating principles related to Health Maintenance Organizations (HMO's). Examination information contained in this report should serve only these purposes. The conclusions and findings of this examination are public record. The preceding statements are not intended to limit or restrict the distribution of this report.

Examiners conducted the examination in accordance with procedures developed by the Colorado Division of Insurance, based on model procedures developed by the National Association of Insurance Commissioners. They relied primarily on records and materials maintained by the Company. The limited market conduct examination covered the period from January 1, 2004, through December 31, 2004.

The examination included review of the following:

Company Operations/Management;
Contract Forms;
Rating;
Applications/Renewals;
Cancellations/Non-renewals/Declinations;
Claims Handling; and
Utilization Review

The final exam report is a report written by exception. References to additional practices, procedures, or files that did not contain improprieties, were omitted. Based on review of these areas, comment forms were prepared for the Company identifying any concerns and/or discrepancies. The comment forms contain a section that permits the Company to submit a written response to the examiners' comments.

For the period under examination, the examiners included statutory citations and regulatory references related to individual, small, and large group health insurance laws as they pertained to health maintenance organizations. Examination findings may result in administrative action by the Division of Insurance. Examiners may not have discovered all unacceptable or non-complying practices of the Company. Failure to identify specific Company practices does not constitute acceptance of such practices. This report should not be construed to either endorse or discredit any health maintenance organization.

An error tolerance level of plus or minus ten dollars ($10.00) was allowed in most cases where monetary values were involved. However, in cases where monetary values were generated by computer or other systemic methodology, a zero dollar ($0) tolerance level was applied in order to identify possible system errors. Additionally, a zero dollar ($0) tolerance level was applied in instances where there appeared to be a consistent pattern of deviation from the Company's established policies, procedures, rules and/or guidelines.

When sampling was involved, a minimum error tolerance level of five percent (5%) was established to determine reportable exceptions. However, if an issue appeared to be systemic, or when due to the sampling process it was not feasible to establish an exception percentage, a minimum error tolerance percentage was not utilized. Also, if more than one sample was reviewed in a particular area of the examination (e.g. timeliness of claims payment), and if one or more of the samples yielded an exception rate of five percent (5%) or more, the results of any other samples with exception percentages less than five percent (5%) were also included.

METHODOLOGY

The examiners reviewed the Company's business practices to determine compliance with Colorado insurance laws and regulations as they pertain to health maintenance organizations. For this examination, special emphasis was given to Health Maintenance Organization requirements and the laws and regulations as shown in Exhibit 1.

Exhibit 1

Law/Regulation	Concerning
Section 10-1-101-10-1-130	General Provisions
Section 10-3-1101-10-3-1104	Unfair Competition - Deceptive Practices
Section 10-16-101-10-16-121	Colorado Health Care Coverage Act: Part I: Short Title - Definitions - General Provisions
Section 10-16-201-10-16-219	Sickness and Accident Insurance
Section 10-16-401-10-16-427	Health Maintenance Organizations
Section 10-16-701-10-16-708	Consumer Protection Standards Act for the Operation of Managed Care Plans
Regulation 1-1-4	Maintenance of Offices in this State
Regulation 1-1-7	Market Conduct Record Retention
Regulation 1-1-8	Penalties and Timelines Concerning Division Inquires and Document Requests
Regulation 4-2-5	Hospital Definition
Regulation 4-2-11	Individual and Group Health Insurance Rate Filings
Regulation 4-2-15	Required Provisions in Carrier Contracts with Providers and Intermediaries Negotiating on Behalf of Providers
Regulation 4-2-16	Women's Access to Obstetricians and Gynecologists under Managed Care Plans
Regulation 4-2-17	Prompt Investigation of Health Plan Claims Involving Utilization Review
Regulation 4-2-18	Concerning the Method of Crediting and Certifying Creditable Coverage for Pre-existing Conditions
Regulation 4-2-21	External Review of Benefit Denials of Health Coverage Plans
Regulation 4-6-9	Conversion Coverage
Regulation 4-7-1	Health Maintenance Organizations
Regulation 4-7-2	Health Maintenance Organization Benefit Contracts and Services in Colorado

Company Operations/Management

The examiners reviewed Company management and administrative controls, the Certificate of Authority, record retention, underwriting guidelines, and timely cooperation with the examination process.

Audits and Examinations

The Company was the subject of a previous market conduct exam in calendar year 2000 that covered the period of January 1, 1999 through December 31, 1999. The Company also underwent a financial audit by the Colorado Division of Insurance in 2000, which covered the period of January 1, 1998 through December 31, 1999.

Contract Forms

The examiners reviewed the following forms:

- The Company Co-payment Schedules, Evidences of Coverage and Schedule of Benefits;
- The Company's most commonly sold HMO group contracts marketed to small groups;
- The Company's HMO conversion contracts, application form, definitions, eligibility, and termination provisions; and
- The Company's group and employee HMO applications/enrollment forms and supporting documents.

These plans were issued and/or certified with the Colorado Division of Insurance (DOI) between January 1, 2004 and December 31, 2004.

Rating

The examiners reviewed the premium rates charged in the samples of the files selected in the Underwriting new business applications section of the examination. These rates were reviewed for compliance with the rate filings submitted to the Colorado Division of Insurance as the rates being used during the examination period as well as for compliance with the appropriate statutes and regulations.

Applications/Renewals

For the period January 1, 2004 through December 31, 2004, the examiners reviewed fifty (50) small group new business application files for compliance with statutory requirements and contractual obligations.

Cancellations/Non-Renewals/Declinations

For the period January 1, 2004 through December 31, 2004, the examiners reviewed the following for compliance with statutory requirements and contractual obligations:

- Forty-five (45) individual cancellation/non-renewal files;
- Fifty (50) small group cancellation/non-renewal files; and
- The entire population of forty-four (44) declined small group files.

Claims

Utilizing ACL™ software, the examiners selected samples of 100 paid and 100 denied HMO claims that were received during the period of January 1, 2004 through December 31, 2004. These claims were reviewed for the Company's overall claims handling practices and to determine accuracy of processing. It was determined that a sample size of 100 claims was appropriate in both of the above samples.

In order to determine the Company's compliance with Colorado's prompt payment of claims law, the examiners also reviewed a random sample of 100 paper claims and 100 electronic claims, not paid within the required timeframes. In addition, the examiners identified 3,758 claims out of a population of 476,764 denied and paid small group claims that were not paid, or settled within ninety (90) days after receipt. The examiners reviewed a randomly selected sample of fifty (50) files from the files not processed within ninety (90) days.

The examiners also reviewed a randomly selected sample of 100 claims that were denied for third party liability in order to assess the Company's handling of these types claims.

Utilization Review

The examiners reviewed the Company's utilization management program including policies and procedures. The examiners also reviewed the entire population of thirty-nine (39) first level appeal files, the entire population of three (3) second level appeal files, the entire population of one (1) external review file and the entire population of twenty-eight (28) reconsideration files.

In addition, the examiners selected a sample of fifty (50) utilization review (UR) denial decision files from a summarized population of ninety-six (96). The examiners also selected a sample of 100 UR certification decisions from a summarized population of 5,609. These sample files were reviewed for the Company's overall UR handling practices, as well as timeliness of completing the review and communication of the decisions to the appropriate persons.

EXAMINATION REPORT SUMMARY

The examination resulted in a total of twenty-two (22) findings in which the Company did not appear to be in compliance with Colorado Statutes and Regulations. The following is a summary of the examiners' findings and recommendations.

Operations/Management: There were no areas on concern found in the review of the operations/management area.

Contract Forms: The examiners identified nine (9) areas of concern in their review of the Company's contract forms (including evidence of coverage forms, employer/employee applications, group service contracts, and any riders).

- Failure of the Company, in some cases, to limit the look-back period in its forms for questions related to health information, to the maximum five (5) year period.
- Failure of the Company's forms, in some cases, to correctly define all the instances that would qualify dependents to enroll after the initial open enrollment period without being considered a late enrollee.
- Failure of the Company to include only appropriate questions in its forms used for determining whether someone qualifies as a disabled dependent.
- Failure of the Company's forms to provide accurate information regarding the rights of members to contact the Colorado Division of Insurance on any and all matters of concern.
- Failure of the Company's forms to exclude or limit coverage for expenses related to the treatment AIDS and HIV related illnesses in a manner consistent with other illnesses or conditions covered by the policy or certificate.
- The Company's forms inequitably represent that sole responsibility for determining if medical services and/or treatments are experimental in nature lies with the Company.
- Failure of the Company to issue separate Health Benefit Plans for Basic and Standard contracts and titling them accordingly.
- Failure of the Company to file and certify its policy form relating to the Colorado Basic Health Benefit Plan.
- Failure of the Company to include a heart/lung transplant in its list of transplants covered under the Colorado Basic and Standard Health Benefit Plans.

Rating: There were no areas on concern found in the review of the rating practices.

Applications/Renewals: The examiners identified two (2) areas of concern in their review of the small group new business files.

- Failure to obtain the required employer provided listing of eligible dependents.
- Failure of the Company's forms, in some instances, to allow eligible employees to enroll in the plan if they are not actively at work.

Cancellations/Non-Renewals/Declinations: There were three (3) areas of concern identified during the review of the individual and small group cancellation/non-renewal/declination files.

- Failure to utilize delinquent premium letters that are not misleading.
- Failure, in some instances, to include required information in certificates of creditable coverage.
- Failure to use policies and procedures in individual plan cancellations, which do not permit unfair discrimination.

Claims: The examiners identified four (4) areas of concern in their review of the claims handling practices of the Company.

- Failure, in some instances, to pay, deny, or settle claims within the time frames required by law.
- Failure, in some instances, to pay interest and/or penalty on claims not processed within the time frames required by law.
- Failure, in some instances, to pay eligible charges or to request the additional information needed to properly adjudicate the claims.
- Failure to establish and maintain claim payment procedures that do not result in unnecessary delays.

The examiners recommend that the Company review its claim processing procedures and quality controls to ensure that claims are processed within the required time frames. The Company should revise its processing of claims that may involve a third party or pre-existing condition. The Company should also revise its procedures regarding claim adjustments to ensure that the original received date is used in all instances where a claim is reopened except if new or additional information from a provider or member is reason the claim was adjusted. Additional training of claims personnel should occur as needed. The Company should work with the division to ensure that any additional benefits due on all underpaid claims resulting from the Company's incorrect received date tracking and delay of payment related to inappropriate investigations of potential third party liability should be paid in a timely manner.

Utilization Review: The examiners identified four (4) areas of concern in their review of the Company's Utilization Review procedures.

- Failure, in some instances, to include all required elements in written notification letters sent to members and providers regarding appeals.

- Failure, in some instances, to make utilization review approval determinations or to notify the member and provider of the determination in the manner and time frame required by Colorado insurance law.

- Failure, in some instances, to provide written notification of adverse utilization review denials or to provide the notifications within the time frames required by Colorado insurance law.

- Failure, in some instances, to include all required elements in written notifications of utilization review denials sent to members and providers.

A copy of the Company's response, if applicable, can be obtained by contacting the Company or the Colorado Division of Insurance. Results of previous Market Conduct Exams are available on the Colorado Division of Insurance website at www.dora.state.co.us/insurance or by contacting the Colorado Division of Insurance.

MARKET CONDUCT EXAMINATION REPORT

FACTUAL FINDINGS

ROCKY MOUNTAIN HEALTH MAINTENANCE ORGANIZATION, INC.

UNDERWRITING
CONTRACT FORM
FINDINGS

Issue E1: Failure of the Company, in some cases, to limit the look-back period in its forms for questions related to medical information, to the maximum five (5) year period.

Section 10-16-105, C.R.S., Small group sickness and accident insurance – guaranteed issue – mandated provisions for basic and standard health benefit plans, states in part:

> (7) *An individual, corporation, association, partnership, or any other entity engaged in the health insurance business subject to this section shall not request or require from a small group applying for coverage, or from an individual in a small group applying for coverage, medical information going back more than five years before the date of application.* [Emphasis added.] Medical information that is more than five years old on any of the enrollee members of a small group shall not be used by the insurer in underwriting or setting premiums for the group. Nothing in this subsection (7) shall preclude a small group health insurer subject to the provisions of part 2 of this article from asking about the current health status of any of the individuals in a group applying for coverage or from using such information on current health status to underwrite or set premiums for the group as provided by law.

It appears that the Company is not in compliance with Colorado insurance law in that some of its application forms require individual enrollees of small employer groups to authorize the Company to obtain medical information without limiting the authorization to the maximum five (5) year look-back period. The Company's certification of handicapped dependents form also requests medical information without limiting the time period for that information to the maximum five (5) year limit.

The Company's application and enrollment forms state the following:

2. We understand and acknowledge that RMHMO and RMHCO or their designated agents/contractors may obtain, use, and disclose information or medical records related to the health of any person proposed for coverage for the treatment, payment, and health care operations functions of RMHMO or RMHCO. For example, these treatment, payment, and health care operation functions of RMHMO or RMHCO include use of such information for processing and payment of claims, in RMHMO or RMHCO quality assurance programs, or to involve me or my dependent(s) in case management. Such information or records may be obtained from any physician, health care provider, hospital, clinic, other medical facility insurance company, or other entity. All information is subject to confidentiality laws. *I authorize any physician, health care provider, hospital or other medical facility, insurance company, or other entity or person that now or hereafter has records or knowledge of the health of any person proposed for coverage to give the health plan such information and supplement such information as requested.* [Emphasis added.]

The Company's Certification for Handicapped Dependents states in part:

Was your Dependent ever institutionalized? Yes No
If yes, give name and address of institution(s):
_____
_____
_____
Period confined: From: _____ To: _____

Section II — Must be Completed by Primary Care Physician
Is Dependent presently incapable of self-sustaining employment by reason of:
Physical Handicap _____ (circle one) Permanent /Temporary
Mental Handicap _____(circle one) Permanent /Temporary
Is incapacity congenital? Yes No
Diagnosis of condition causing handicapped status:

Form	Form Number
Application – Business Group of One	MK100R1104
Enrollment Form – Group Coverage	MK235R1004
Application for Conversion Coverage	MK181R1004
Request for Coverage For a Physically or Mentally Handicapped Dependent Child	MS35R0403

Recommendation No. 1:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all applicable forms to ensure that questions related to health status are limited to the maximum five (5) year look-back period as required by Colorado insurance law.

Issue E2: Failure of the Company's forms, in some cases, to correctly define all the instances that would qualify dependents to enroll after the initial open enrollment period without being considered a late enrollee.

Section 10-16-102, C.R.S., Definitions, states in part:

> 26) "Late enrollee" means an eligible employee or dependent who requests enrollment in a group health benefit plan following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, if such initial enrollment period is a period of at least thirty days. An eligible employee or dependent shall not be considered a late enrollee if:
>
> (a) The individual:
>
> (I) Was covered under other creditable coverage at the time of the initial enrollment period and, if required by the carrier or issuer, the employee stated at the time of initial enrollment that this was the reason for declining enrollment;
>
> (II) Lost coverage under the other creditable coverage as a result of termination of employment or eligibility, reduction in the number of hours of employment, the involuntary termination of the creditable coverage, death of a spouse, legal separation or divorce, or employer contributions towards such coverage was terminated; and
>
> (III)Requests enrollment within thirty days after termination of the other creditable coverage; or
>
> (b) The individual is employed by an employer that offers multiple health benefit plans and elects a different plan during an open enrollment period;
>
> (c) A court has ordered that coverage be provided for a dependent under a covered employee's health benefit plan and the request for enrollment is made within thirty days after issuance of such court order; or
>
> (d) A person becomes a dependent of a covered person through marriage, birth, adoption, or placement for adoption and requests enrollment no later than thirty days after becoming such a dependent. In such case, coverage shall commence on the date the person becomes a dependent if a request for enrollment is received in a timely fashion before such date.

It appears that the Company's forms are incomplete and potentially misleading in that neither the business group of one application form, nor the standard enrollment form, correctly define all the instances that would qualify dependents to enroll after the initial open enrollment period without being considered a late enrollee. The Company's forms allow for coverage within thirty (30) days of marriage, birth, adoption, or placement for adoption but fail to also allow for enrollment in the case of loss of creditable coverage by a dependent on the Business Group of One application and loss of creditable

coverage and court ordered coverage are not included on the Group Coverage Enrollment Form and the Employee/Dependent Waiver forms.

The Company's "Enrollment Form – Group Coverage" and "Employee/Dependent Waiver", state the following:

6. I understand that if I decline coverage for myself or my dependents (including my spouse) because of other insurance coverage, I may, in the future, be able to enroll myself or my dependents (if I am already enrolled) in this plan as required by applicable law, provided I request enrollment within 30 days after other coverage ends. *I also understand that if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll myself and my dependents provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.* [Emphasis added.] I understand that if I do not request enrollment within 30 days for the above events, I will not be eligible for enrollment for such coverage until whichever of the following dates occur first (1) the date I enroll for such coverage during an Annual Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage. I also understand that if I do not list a dependent on this form who has other coverage, I can't enroll this dependent until whichever of the following dates occur first (1) the date I enroll for such coverage during an Annual Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage. I also understand that, upon enrollment, I and/or my dependent(s) may be subject to a pre-existing condition limitation period.

The Company's "Application – Business Group of One" form, states in part:

6. I understand that if I decline coverage for my dependents (including my spouse) because of other insurance coverage, I may, in the future, be able to enroll my dependents (if I am already enrolled) in this plan as required by applicable law, provided I request enrollment within 30 days after other coverage ends. *I also understand that if I have a new dependent as a result of marriage, birth, adoption, or placement for adoption, I may be able to enroll my dependents provided that I request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.* [Emphasis added.] I understand that if I do not request enrollment within 30 days for the above events, my dependent(s) will not be eligible for enrollment for such coverage until whichever of the following dates occur first (1) the date I enroll my dependents for such coverage during an Annual Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage. I also understand that if I do not list a dependent on this form who has other coverage, I cannot enroll this dependent until whichever of the following dates occur first (1) the date I enroll my dependent(s) for such coverage during an Annual Open Enrollment Period; or (2) the date twelve (12) months following the date I first request such coverage. I also understand that, upon enrollment, my dependent(s) may be subject to a pre-existing condition limitation period. I further understand that if my dependent(s) (other than a newborn, adopted child, child placed for adoption, or child subject to a court order for health care coverage) were not medically underwritten at the time I initially enrolled in this plan, then my dependent(s) must pass medical underwriting to enroll in any plan subject to the above requirements, except that no medical screening will be required to enroll in an RMHMO HMO or RMHCO PPO Basic Health Benefit Plan Without Specified Mandates or Standard Health Benefit Plan for Colorado.

Form	Form Number
Application – Business Group of One	MK100R1104
Enrollment Form – Group Coverage	MK235R1004
Employee/Dependent Waiver	MK105R1004

Recommendation No.2:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised all affected forms to correctly define all instances that would qualify dependents to enroll after the initial open enrollment period without being considered a late enrollee, to ensure compliance with Colorado insurance law.

Issue E3: Failure of the Company to include only appropriate questions in its form used for determining whether someone qualifies as a disabled dependent.

Section 10-16-102, C.R.S., Definitions, states in part:

> (14) "Dependent" means a spouse, an unmarried child under nineteen years of age, an unmarried child who is a full-time student under twenty-four years of age and who is financially dependent upon the parent, and *an unmarried child of any age who is medically certified as disabled and dependent upon the parent.* [Emphasis added.]

It appears that the Company is not in compliance with Colorado insurance law in that its "Request for Coverage For a Physically or Mentally Handicapped Dependent Child" form is too restrictive. Colorado insurance law only requires that the dependent be medically certified as disabled and dependent upon the parent; however, the Company's form includes questions that seem to imply that it has a more stringent standard for determining who qualifies as a disabled dependent. Specifically, Colorado law does not use employment status, degree of disability, or type of disability in determining whether someone qualifies as a disabled dependent.

The Company's Certification for Handicapped Dependents states the following:

Section I — To be Completed by Subscriber

Date of Disability: _____ /_____/_____
Month Day Year
Was your Dependent ever institutionalized? Yes No
If yes, give name and address of institution(s):
Period confined: From: _____To:_____
Is your Dependent eligible for care under federal, state or local law? Yes No
If yes, give details:
Was, or is, your Dependent employed for wages? Yes No
If yes, give details:
Average weekly earnings: $ _____

Section II — Must be Completed by Primary Care Physician

Is Dependent presently incapable of self-sustaining employment by reason of:
Physical Handicap _____ (circle one) Permanent /Temporary
Mental Handicap _____(circle one) Permanent /Temporary
Is incapacity congenital? Yes No
Diagnosis of condition causing handicapped status:

Form	Form Number
Request for Coverage For a Physically or Mentally Handicapped Dependent Child	MS35R0403

Recommendation No. 3:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-102, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its certification of handicapped dependent form to only include questions directly related to the dependent's disability and dependence on the parent as required by Colorado insurance law.

Issue E4: Failure of the Company's forms to provide accurate information regarding the rights of members to contact the Colorado Division of Insurance on any and all matters of concern.

Section 10-3-1104(1)(b), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> False information and advertising generally: Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public, in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading;

Regulation 6-2-1, Complaint Record Maintenance, promulgated pursuant to Section 10-3-1110, C.R.S., effective July 1, 1974, states in part:

> (VI) Definitions
>
> For the purposes of this regulation:
>
> "Complaint" shall mean a written communication primarily expressing a grievance;...

It appears that the Company is not in compliance with Colorado insurance law in that the "Mandatory Complaint Procedures" section of its Health Benefits Contract form is overly restrictive and misleading. The Company's Health Benefit Contract appears to indicate that its members are only allowed to contact the Division of Insurance in matters relating to covered benefits. Colorado insurance law does not restrict in any way the type or subject matter of a complaint that may be referred to the Division for resolution.

The Company's Health Benefits Contract states the following:

10. MANDATORY COMPLAINT PROCEDURES

H. Referral to Insurance Commissioner:

Any complaint, controversy, dispute or disagreement *as to whether any health care service is a Benefit covered under the provisions of this Contract* may be referred to the Insurance Commissioner of the State of Colorado. [Emphasis added.]

Form	Form Number
HMO Standard and Basic Health Benefit Contract for Colorado	HMO-2004-B&S-G&C-HBC-01-104
HMO Basic Health Benefit Plan without Specified Mandates for Colorado and HMO Standard Health Benefit Plan for Colorado	HMO-2004-B&S-G&C-HBC-01-104
Group Health Benefit Contract	HMO-2004-Group-G-HBC-01-104

Recommendation No. 4:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Mandatory Complaint Procedures to comply with Colorado insurance law.

Issue E5: Failure of the Company's forms to exclude or limit coverage for expenses related to the treatment of AIDS and HIV related illnesses in a manner consistent with other illnesses or conditions covered by the policy or certificate.

Regulation 4-2-9, Concerning Non-Discriminatory Treatment of Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Related Illness By Life And Health Carriers, promulgated pursuant to Section 10-1-109, 10-1-1104.5(3)(d)(II) and 10-3-1110 C.R.S., amended effective April 1, 2000, states in part:

Section 5 Standards

O. Insurance coverage which excludes or limits coverages for expenses related to the treatment of AIDS and HIV related illness or complications of AIDS, e.g., opportunistic infection resulting from AIDS, will not be approved for use in Colorado, except to the extent that such exclusions or limitations are consistent with the exclusions or limitations applicable to other covered illnesses or conditions covered by the policy or certificate.

It appears that the Company is not in compliance with Colorado insurance law in that the "Benefits, Limitations and Exclusions" section of its Health Benefits Contract form specifically excludes "experimental services" and defines them as "Experimental services include, but are not limited to experimental drugs and certain treatments of the virus associated with Acquired Immune Deficiency Syndrome (AIDS)". While the Company's contracts do contain a generic disclaimer, the contract does not list any other medical condition or disease under its experimental services exclusions. Therefore, the Company's stated exclusion of "certain treatments" of the AIDS virus is not consistent with the exclusions of other covered illnesses or conditions.

The Company's Health Benefits Contract states the following:

2. BENEFITS, LIMITATIONS AND EXCLUSIONS

C. Limitations and Exclusions

(3) <u>Specific Exclusions</u>

(m) RMHMO may, at its sole discretion, also consider any local, community standard with respect to each service in question, and inquire as to the coverage of such service by group health insurance companies and other health maintenance organizations in the Service Area. *Experimental services include, but are not limited to experimental drugs and certain treatments of the virus associated with Acquired Immune Deficiency Syndrome (AIDS)*. Any other service determined by the Medical Director to be experimental or investigative is excluded. [Emphasis added.]

Form	Form Number
HMO Standard and Basic Health Benefit Contract for Colorado	HMO-2004-B&S-G&C-HBC-01-104
HMO Basic Health Benefit Plan without Specified Mandates for Colorado and HMO Standard Health Benefit Plan for Colorado	HMO-2004-B&S-G&C-HBC-01-104
Group Health Benefit Contract	HMO-2004-Group-G-HBC-01-104

Recommendation No. 5:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-2-9. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Limitations and Exclusions Provisions to comply with Colorado insurance law.

Issue E6: The Company's forms inequitably represent that the sole responsibility for determining if medical services and/or treatments are experimental in nature lies with the Company.

Section 10-16-107, C.R.S., Rate regulation – approval of policy forms – benefit certificates – evidences of coverage – loss ratio guarantees – disclosures on treatment of intractable pain, states in part:

> (3)(b) An evidence of coverage shall contain:
>
> > (I) *No provisions or statements* which are unjust, unfair, *inequitable*, misleading, or deceptive, which encourage misrepresentation, or which are untrue, misleading, or deceptive as defined in section 10-16-413 (1); [Emphases added.]

It appears that the Company is not in compliance with Colorado insurance law in that the "Benefits, Limitations and Exclusions" section of its Health Benefits Contract form inequitably represents that the Company is solely responsible for determining what medical services and/or treatments are experimental in nature. The wording of the Company's contract appears to allow the Company and its Medical Director to make a determination of what is experimental treatment without consideration as to what is generally accepted to be experimental treatment in the medical community. This wording could allow the Company to deny benefits for a treatment that it deems to be experimental, even though it may not be considered as such by established experts in the medical community.

The Company's Health Benefits Contract states the following:

3. BENEFITS, LIMITATIONS AND EXCLUSIONS

C. Limitations and Exclusions

(4) <u>Specific Exclusions</u>

a. *Services determined by RMHMO to be experimental in nature*. Whether a service is experimental may be determined by RMHMO either before or after a Member requests that RMHMO provide such service as a Benefit. *RMHMO will determine the experimental nature of a medical service through RMHMO's medical department and the Medical Director*. RMHMO may, *in its sole discretion*, review material from or seek input from the following groups:

The Food and Drug Administration
The National Institute of Health
The American Medical Association

RMHMO may, *in its sole discretion*, also consider any local, community standard with respect to each service in question, and inquire as to the coverage of such service by group health insurance companies, and other health maintenance organizations in the Service Area. Experimental services include, but are not limited to experimental drugs and certain treatments of the virus associated with the Acquired Immune Deficiency Syndrome (AIDS). *Any other service determined by the Medical Director to be experimental or investigative is excluded*. [Emphases added.]

Form	Form Number
HMO Standard and Basic Health Benefit Contract for Colorado	HMO-2004-B&S-G&C-HBC-01-104
HMO Basic Health Benefit Plan without Specified Mandates for Colorado and HMO Standard Health Benefit Plan for Colorado	HMO-2004-B&S-G&C-HBC-01-104
Group Health Benefit Contract	HMO-2004-Group-G-HBC-01-104

Recommendation No. 6:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-107, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its Benefits, Limitations and Exclusions provisions to comply with Colorado insurance law.

Issue E7: Failure of the Company to issue separate Health Benefit Plans for Basic and Standard Health Benefit Plan contracts and to title them accordingly.

Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., effective January 1, 2004, states in part:

3. RULES

A. 1. Standard Plan. *The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market* pursuant to Section 10-16-105(7.3), C.R.S., and for use as an conversion coverage pursuant to Section 10-16-108, C.R.S.

2. Basic Plan. T*he form and content of the basic health benefit plan, as appended to this regulation, shall constitute the basic health benefit plan design* pursuant to Section 10-16-105 (7.2), C.R.S., and shall be required for use in Colorado's small group market pursuant to Section 10-16-105 (7.3), C.R.S. and as conversion coverage pursuant to Section 10-16-108, C.R.S. In addition to offering this plan basic plan design, a small group carrier may offer options pursuant to Section 10-16-105(7.2)(b)(II), C.R.S.

B. The basic and standard health benefit plans shall be identified as specified below.

1. Each small employer carrier shall title and market its basic health benefit plan as follows: "[Carrier name][Type of plan (i.e., Indemnity, Preferred Provider or HMO)] Basic Health Benefit Plan for Colorado."

2. Each small employer carrier shall title and market the standard health benefit plan as follows: [Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider, or HMO] Standard Health Benefit Plan for Colorado." [Emphases added.]

. . . .

Emergency Regulation 04-E-4, The Basic And Standard Health Benefit Plans, promulgated pursuant to Sections 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., effective July 1, 2004, states in part:

3. RULES

A. 1. Standard Plan. *The form and content of the standard health benefit plan, as appended to this regulation, shall constitute the standard health benefit plan required for use in Colorado's small employer market* pursuant to Section 10-16-105(7.3), C.R.S., and for use as conversion coverage pursuant to Section 10-16-108, C.R.S.

2. Basic Plan. *The form and content of the basic health benefit plan may be one or more of the three design options, as appended to this regulation, and shall constitute the basic health benefit plan* design pursuant to Section 10-16-105 (7.2), C.R.S. At least one of these three

plan design options shall be required for use in Colorado's small group market pursuant to Section 10-16-105 (7.3), C.R.S. and as conversion coverage pursuant to Section 10-16-108, C.R.S. However, if the carrier chooses to offer more than one basic health benefit plan design, it shall offer all of its basic plan options to every small employer that expresses an interest in the basic plan or to those individuals purchasing a basic conversion plan.

B. The basic and standard health benefit plans shall be identified as specified below.

1. Each small employer carrier shall title and market its basic health benefit plan as follows: "[Carrier name][Type of plan (i.e., Indemnity, Preferred Provider or HMO)] Basic (Health Benefit Plan without Specified Mandates, High Deductible Health Benefit Plan or High Deductible Health Benefit Plan without Specified Mandates)] for Colorado."

2. Each small employer carrier shall title and market the standard health benefit plan as follows: [Carrier name] [Type of plan (i.e., Indemnity, Preferred Provider, or HMO] Standard Health Benefit Plan for Colorado." [Emphases added.]

. . . .

It appears that the Company is not in compliance with Colorado insurance law in that its Health Benefit Plan Contracts for the Colorado Basic and Standard plans are combined in one document as opposed to being titled separately as required by Colorado insurance law. Additionally, this formatting of the Colorado Basic and Standard health benefit plans is potentially confusing to the Member when attempting to determine the benefits provided to them under their contract. The Company's Health Benefits Contract are titled as follows:

ROCKY MOUNTAIN HEALTH PLANS
HMO STANDARD AND BASIC
HEALTH BENEFIT PLANS FOR COLORADO
HEALTH BENEFIT CONTRACT

and

ROCKY MOUNTAIN HEALTH PLANS
HMO BASIC HEALTH BENEFIT PLAN WITHOUT SPECIFIED MANDATED FOR COLORADO
AND
HMO STANDARD HEALTH BENEFIT PLAN FOR COLORADO

Form	Form Number
HMO Standard and Basic Health Benefit Contract for Colorado	HMO-2004-B&S-G&C-HBC-01-104
HMO Basic Health Benefit Plan without Specified Mandates for Colorado and HMO Standard Health Benefit Plan for Colorado	HMO-2004-B&S-G&C-HBC-01-104

Recommendation No. 7:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to issue separate contracts for Basic and Standard Health Benefit Plans and to title them accordingly in compliance with Colorado insurance law.

Issue E8: Failure of the Company to file and certify its policy form relating to the Colorado Basic Health Benefit Plan.

Section 10-16-107, C.R.S., Rate regulation – approval of policy forms – benefit certificates – evidences of coverage – loss ratio guarantees – disclosures on treatment of intractable pain, states in part:

> (4) No policy of sickness and accident insurance or subscription certificate or membership certificate or other evidence of health care coverage shall be delivered or issued for delivery in this state, nor shall any endorsement, rider or application that becomes a part of any such policy, contract, or evidence of coverage be used, until the insurer had filed a certification with the commissioner that such policy, endorsement, rider, or application conforms, to the best of insurer's good faith knowledge and belief, to Colorado law pursuant to section 10-16-107.2 and copies of the rates and the classification of risks or subscribers pertaining thereto are filed with the commissioner.

Section 10-16-107.2, C.R.S., Filing of health policies, states in part:

> (2) All sickness and accident insurers, health maintenance organizations, nonprofit hospital and health service corporations, and other entities providing health care coverage authorized by the commissioner to conduct business in Colorado shall also submit to the commissioner a list of any new policy form, application, endorsement or rider at least thirty-one days before using such policy form, application, endorsement, or rider for any health coverage. Such listing shall also contain a certification by an officer of the organization that such new policy form, application, endorsement, or rider proposed to be used complies, to the best of the insurer's good faith knowledge and belief, with Colorado law. The necessary elements of the certification shall be determined by the commissioner.

Amended Regulation 1-1-6, Concerning The Elements of Certification For Accident and Health Forms, Private Passenger Automobile Forms, Commercial Automobile with Individually-Owned Private Passenger Automobile Forms, Claims-Made Liability Forms, Preneed Funeral Contracts and Excess Loss Insurance in Conjunction with Self-Insured Employer Benefit Plans under the Federal "Employee Retirement Income Security Act", promulgated pursuant to Sections 10-1-109, 10-4-419, 10-4-633, 10-15-105, 10-16-107.2 and 10-16-119, C.R.S., amended effective February 1, 2004, reads in part:

Section 4. Definitions

M. "Listing of New Policy Forms for health coverage" shall mean a list of any new policy forms, application forms (to include any health questionnaires used as part of the application process), endorsements and riders for any sickness, accident and/or health insurance policy, contract, certificate, or other evidence of coverage issued or delivered to any policyholder, certificate holder, enrollee, subscriber, or member in Colorado and the title of the program or product affected by the forms, and the effective date the form will be used.

Section 5. Rules

A. At least 31 days prior to using any new form (except preneed funeral contracts and excess loss insurance used in conjunction with self-insured employer benefit plans under the federal "Employee Retirement Income Security Act" forms, which are filed concurrently) each entity, subject to the provisions of this regulation, shall file, in a format prescribed by the Commissioner, a Listing of New Policy Forms including a fully-executed certificate of compliance. Any such listing and the applicable certificate of compliance must be prepared individually for each product.

It appears that the Company is not in compliance with Colorado insurance law in that the Company failed to file and certify its policy form relating to the Colorado Basic Health Benefit Plan upon modification of title and/or benefits of its policy form as required by Emergency Regulation 04-E-4. In a February 6, 2006 memo to the examiners, the Company states that "Although the title of the Companies' Basic plans were changed in July 2004 to comply with Emergency Regulation 04-E-4, no new policy forms were necessary at that time as a result to the changes in the law. Therefore, no form filing for new policy forms was necessary in July 2004 under Regulation 1-1-6".

The Division of Insurance respectfully disagrees with the Company's position in this regard. A revised title and/or change in benefits requires a filing of a Listing of New Policy Forms for health coverage (to include the date of usage of the form) as set-forth in Colorado insurance law, along with the required Company certification of Compliance at least thirty-one (31) days before use.

Form	Form Number
HMO Basic Health Benefit Plan without Specified Mandates for Colorado and HMO Standard Health Benefit Plan for Colorado	HMO-2004-B&S-G&C-HBC-01-104

Recommendation No. 8:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-16-107 and 10-16-107.2, C.R.S., and Colorado Insurance Regulation 1-1-6. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to file and certify policy forms in compliance with Colorado insurance law.

Issue E9: Failure of the Company to include a heart/lung transplant in its list of transplants covered under the Colorado Basic and Standard Health Benefit Plans.

Amended Regulation 4-6-5, Implementation of Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., effective January 1, 2004, states in part:

. . . .

STANDARD AND BASIC HEALTH BENEFIT PLAN
POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
January 1, 2004

I. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b)(IV), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in the attached table labeled "Basic Health Benefit Plan*."

II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan*." [Emphases added.]

. . . .

Benefit Grids:

2004 COLORADO BASIC HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	INDEMNITY PLAN	**BASIC PREFERRED PROVIDER PLAN**		**BASIC HMO PLAN**
		IN NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
24. ORGAN TRANS-PLANTS[18]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			

	50%	70%	50%	Coverage is no less extensive than the coverage for any other physical illness.

18. Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

. . . .

2004 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	STANDARD INDEMNITY PLAN	**STANDARD PREFERRED PROVIDER PLAN**		**STANDARD HMO PLAN**
24. ORGAN TRANS-PLANTS[22]		**IN-NETWORK**	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			
	80%	80%	60%	Coverage is no less extensive than the coverage for any other physical illness.

22. Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

. . . .

Emergency Regulation 04-E-4, The Basic and Standard Health Benefit Plans, promulgated pursuant to §§ 10-1-109, 10-16-105(7.2), 10-16-108.5(8), and 10-16-109, C.R.S., effective July 1, 2004, states in part:

. . . .

STANDARD AND BASIC HEALTH BENEFIT PLAN

POLICY REQUIREMENTS FOR THE STATE OF COLORADO

Colorado Division of Insurance
July 1, 2004

I. The basic health benefit plan as defined by the Commissioner pursuant to 10-16-105(7.2)(b), C.R.S., for an indemnity, preferred provider, and health maintenance organization (HMO) plan *shall include the specific benefits and coverages outlined in one of the attached table labeled "Basic Health Benefit Plan without Specified Mandates", "Basic High Deductible Health Benefit Plan", or "Basic High Deductible Health Benefit Plan without Specified Mandates*."

II. The standard health benefit plan for an indemnity, preferred provider, and HMO plan *shall include the specific benefits and coverages outlined in the attached table labeled "Standard Health Benefit Plan*." [Emphases added.]

. . . .

Benefit Grids:

2004 COLORADO BASIC HEALTH BENEFIT PLANS WITHOUT SPECIFIED MANDATES: INDEMNITY, PREFERRED PROVIDER, AND HMO

. . . .

PART B: SUMMARY OF BENEFITS

(Please note: all co-insurance percentages listed are what the carrier will pay for service. For the HMO plan, the percentage copay listed is what the member will pay.)

	BASIC INDEMNITY PLAN	**BASIC PREFERRED PROVIDER PLAN**		**BASIC HMO PLAN**
Basic Health Benefit Plan without Specified Mandates		**IN-NETWORK**	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
24. ORGAN TRANS-PLANTS[18]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			
	50% Coinsurance	70% Coinsurance	50% Coinsurance	Coverage is no less extensive than the coverage for any other physical illness.

18. Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

. . . .

2004 COLORADO STANDARD HEALTH BENEFIT PLANS: INDEMNITY, PREFERRED PROVIDER, AND HMO

PART B: SUMMARY OF BENEFITS

	STANDARD INDEMNITY PLAN	**STANDARD PREFERRED PROVIDER PLAN**		**STANDARD HMO PLAN**
		IN-NETWORK	**OUT-OF-NETWORK** [1a]	**IN-NETWORK ONLY (out-of-network care is not covered except as noted)**
24. ORGAN TRANS-PLANTS[22]	Covered transplants include: liver, heart, heart/lung, lung, cornea, kidney, kidney/pancreas, and bone marrow for Hodgkin's, aplastic anemia, leukemia, immunodeficiency disease, neuroblastoma, lymphoma, high risk stage II and III breast cancer, and Wiskott-Aldrich syndrome only. Peripheral stem cell support is a covered benefit for the same conditions as listed above for bone marrow transplants.			
	80% co-insurance	80% co-insurance	60% co-insurance	Coverage is no less extensive than the coverage for any other physical illness.

22. Transplants will be covered only if they are medically necessary and meet clinical standards for the procedure.

. . . .

It appears that the Company is not in compliance with Colorado insurance law in that the description of covered transplant procedures contained in the Company's "Health Benefit Contract" does not contain one of the transplant procedures required to be covered under the Basic and Standard health benefit plans. The Company's forms appear to fail to provide coverage for a heart/lung transplant.

If the Company intended to provide this coverage under paragraph (v) of the Terms and Limitations for Transplants contained in its Health Benefit Contracts, the examiners feel that the wording of this paragraph needs to be clarified to clearly state that a heart/lung transplant is a covered benefit. As it currently reads, the wording of this paragraph has the potential to be confusing to a Member.

The Company's "HMO Standard and Basic Health Benefit Plans for Colorado Health Benefits Contract " and "HMO Basic Health Benefit Plan Without Specified Mandates For Colorado And HMO Standard Health Benefit Plan For Colorado" state in part the following:

2. BENEFITS, LIMITATIONS AND EXCLUSIONS

. . . .

B. Schedule of Benefits

. . . .

(29) Transplants

Coverage. Subject to the terms of this subparagraph, coverage is provided only for the following transplants or transferred body components when (i) Medically Necessary, (ii) the transplant facility meets clinical standards for the procedure, and (iii) the Member's Participating Physician and the Medical Director agree it is Medically Necessary for the Member to receive the transplant or transferred body components:

(a) Cornea;
(b) Kidney and simultaneous kidney and pancreas;
(c) Liver;
(d) Heart;
(e) Lung;
(f) Autologous or allogeneic human bone marrow of peripheral stem cells for the following conditions:
- Leukemia or aplastic anemia;
- Immunodeficiency Disease;
- Wiskott-Aldrich Syndrome;
- Neuroblastoma;
- Hodgkin's Disease;
- Lymphoma; or
- High risk stage II and stage III breast cancer.

Terms and Limitations. Coverage for transplants or transferred body components is subject to the following terms and limitations:

. . . .

(v) In the event of a multiple organ transplant that includes an organ listed in subparagraphs (b) through (e) above, except for a pancreas separate from a simultaneous kidney and pancreas transplant, and one or more organs not listed in such paragraph:

- coverage shall be provided only for the transplant of the organ listed in subparagraphs (b) through (e) above, and
- coverage shall not be provided for the transplant of any other organ not listed in subparagraphs (b) through (e) above, or for any costs or expenses related to such transplant.

. . . .

Form	Form Number
HMO Standard and Basic Health Benefit Plan For Colorado Health Benefits Contract	HMO-2004-B&S-G&C-HBC-01-104

HMO Basic Health Benefit Plan Without Specified Mandates For Colorado and HMO Standard Health Benefit Plan For Colorado	HMO-2004-BAS-G&C-CS-01-104

Recommendation No. 9:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Regulation 4-6-5. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its forms to clearly state that heart/lung transplants are a covered benefit under the Colorado Basic and Standard Health Benefit Plans.

UNDERWRITING – NEW BUSINESS
FINDINGS

Issue G1: Failure to obtain the required employer provided listing of eligible dependents.

Regulation 4-6-8, amended effective March 2, 2003, Concerning Small Employer Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV) and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, and 10-16-708, C.R.S., states in part:

> Section 5. Issuance Of Coverage
>
> B. Determining Who is an Eligible Employee, Dependent
>
> (3) A small employer carrier shall require each small employer that applies for coverage, as part of the application process, to provide a *complete list of eligible employees and dependents of eligible employees, and a list of employer-determined eligible employees and dependents, if this is a different list.* [Emphasis added.] The small employer carrier may require the small employer to provide appropriate supporting documentation, such as the Unemployment Insurance Quarterly Wage and Tax Report (UITR) often referred to as a W-2 Summary Wage and Tax Form, to verify the information required under this paragraph. In the event that a UITR form is not available because the employer was not in business during the preceding quarter or the employer has outsourced payroll functions, the carrier shall accept reasonable alternate documentation for this information. Alternate documentation includes, but is not limited to, payroll documentation from the company or the company's payroll administrator or employee leasing company; organizational documents; or other reasonable proof.

NEW BUSINESS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
347	50	50	100%

The examiners reviewed a randomly selected sample of fifty (50) files from a population of 347 representing new small group applications issued during the exam period of January 1 through December 31, 2004. Based on the files examined it appears that the Company is not in compliance with Colorado insurance law in that none of the sample files contained a list of eligible employees and *dependents*. The examiners also reviewed the company's underwriting policy/procedure manual and it does not appear that a list of eligible dependents is required as part of the underwriting process.

Recommendation No. 10:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all small employer groups submit an employer provided listing of eligible dependents as required by Colorado insurance law.

Issue G2: Failure of the Company's forms, in some instances, to provide for eligible employees to enroll in the plan if they are not actively at work.

Section 10-16-102, C.R.S., Definitions, states in part:

> (15) (a) "Eligible employee" means an employee who has a regular work week of twenty-four or more hours and includes a sole proprietor and a partner of a partnership if the sole proprietor or partner is included as an employee under a health benefit plan of a small employer, but does not include an employee who works on a temporary or substitute basis.
>
> (b) Notwithstanding any provision of law to the contrary, an eligible employee of a small employer who could also be considered a dependent of the small employer shall receive taxable income from such small employer in an amount equivalent to minimum wage for working twenty-four hours per week on a permanent basis in order for the employer group to be considered a business group of two or more.
>
> (c) Nothing in this subsection (15) is intended to limit the employer's traditional ability to set valid and acceptable standards for employee eligibility based on the terms and conditions of employment, including a minimum weekly work requirement in excess of twenty-four hours and eligibility based upon salaried versus hourly workers and management versus nonmanagement employees.

Section 10-16-105, C.R.S., Small group sickness and accident insurance - guaranteed issue - mandated provisions for basic and standard health benefit plans – rules, states in part:

> (7.3)(a) Except as otherwise provided in this subsection (7.3), effective January 1, 1995, every small employer carrier shall, as a condition of transacting business in this state with small employers, actively offer to such small employers the choice of a basic health benefit plan or a standard health benefit plan. Effective July 1, 1997, every small employer carrier shall also offer to small employers a choice of all the other small group plans the carrier markets in Colorado; except that this requirement shall not apply to a health benefit plan offered by a carrier if such plan is made available in the small group market only through one or more bona fide association plans and except as provided in paragraph (i) of this subsection (7.3).

Regulation 4-6-8, amended effective March 2, 2003, Concerning Small Employer Health Plans, promulgated under the authority of Sections 10-1-109(1), 10-8-601.5(1)(a)(IV) and (3), 10-16-105(5), 10-16-108.5(8), 10-16-109, and 10-16-708, C.R.S., states in part:

> Section 5. Issuance Of Coverage

B. Determining Who is an Eligible Employee, Dependent

(2) The Division finds that, subject to other statutory restrictions and the provisions of this regulation, a small employer carrier may offer a health benefit plan to the eligible employees of a small employer as that employer defines its eligible employees (herein after referred to as "employer-determined eligible employees"). However, a carrier must offer coverage to all small employers for all employees with a regular work week of at least 24 hours on a permanent basis. The decision of a small employer to limit eligibility for coverage as provided for in subparagraph (1) of this subsection B shall be solely at the small employer's discretion, without direct or indirect pressure or suggestion by the carrier, producer, or their representatives. The small employer carrier may offer coverage only to such employer-determined eligible employees and their dependents and may apply its minimum participation and contribution criteria solely to such employer-determined eligible employees.

NEW BUSINESS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
347	50	45	90%

The examiners reviewed a randomly selected sample of fifty (50) files from a population of 347 representing HMO new small group applications issued during the exam period of January 1 through December 31, 2004. Based on the files examined it appears that the Company is not in compliance with Colorado insurance law in that forty-five (45) of the files contained a requirement that employees be actively at work at the time of the application. Colorado law requires that small employers offer the same coverage to all eligible employees and dependents. However, it does not define an eligible employee as someone who is actively at work.

The Company's "Application for Health Benefits For Groups with 2 or More Employees" states the following:

> Eligible employees must be actively-at-work, working at least the required number of hours a week, and must satisfy and applicable eligibility waiting period.

Recommendation No. 11:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-105, C.R.S., and Regulation 4-6-8. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its application forms to exclude any actively-at-work requirement, to ensure compliance with Colorado insurance law.

UNDERWRITING
CANCELLATIONS/NON-RENEWALS/DECLINATIONS
FINDINGS

Issue H1: Failure to utilize delinquent premium letters that are not misleading.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

(1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:

(b) False information and advertising generally: Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading;

Section 10-16-103.5, C.R.S., Payment of premiums – required term in contract, states:

(1) Every contract between a carrier and a policyholder shall contain a provision that requires a policyholder to pay premiums:

(a) For each individual covered under the policyholder's policy through the date that the policyholder notifies the carrier that the individual covered under the policy is no longer eligible or covered; or

(b) Through the date that the policyholder notifies the carrier that the policyholder no longer intends to maintain coverage for the group through the carrier.

(2) Premiums shall be paid according to the premium payment provisions of the contract.

INDIVIDUAL CANCELLED SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
275	45	3	7%

The examiners reviewed a randomly selected sample of fifty (50) files from a population of 275 HMO individual policies cancelled/nonrenewed/rescinded during the examination period of January 1, 2004 to December 31, 2004. It appears that the Company is not in compliance with Colorado insurance law in that in three (3) instances, a form letter used to notify the member of delinquent premiums is misleading.

This letter contains no form number or revision date but is referenced as "NSF Individual Term". The letter states in paragraph three:

> A new law that took effect January 1, 2003, *obligates policyholders to pay additional premium when the policyholder fails to provide timely notice of cancellation of the plan*. [Emphasis added.] If your intention is to terminate your policy, you still owe premiums for [MONTH], regardless of any new and duplicative coverage you may have purchased through another carrier and regardless of any premium that has already been paid to the new carrier.

Also, while reviewing the sample of policies cancelled/nonrenewed/rescinded during the examination period, the examiners encountered a form letter used to notify the Benefits Administrator of a group's delinquent premiums. This letter contains no form number or revision date. The letter states in paragraph three:

> Effective January 1, 2003, a new law *obligates policyholders to pay additional premium when the policyholder fails to provide timely notice of cancellation of the plan*. [Emphasis added.] Therefore, if your intention is to terminate your Group Service Agreement, you still owe premiums for [MONTH], regardless of any new and duplicative coverage you may have purchased through another carrier and regardless of any premium that has already been paid to the new carrier. If you have cancelled your RMHP plan, please notify us in writing and include payment of the premium currently due by [DATE].

The first line of these paragraphs appears to be misleading to the consumer and may constitute a violation of 10-3-1104, C.R.S. The examiners acknowledge that there is a statutory requirement that carriers include provisions in their contract requiring that the policyholder pay premiums through the date of written notice of cancellation of the plan. The examiners also acknowledge that carriers may require that the policyholder be liable to the carrier for payment of pro rata premiums for the time coverage was in force during a grace period. Without statutory reference in the Company's communication the lay consumer may be misled to believe that any additional monies due are the result of law, not of a contract provision. Additionally, the wording appears to have a punitive inference that the policyholder is being charged *additional* premium for their actions, not that they are being charged the pro rata premium until the date written notice is received.

Recommendation No. 12:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104 and 10-16-103.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its small group cancellation procedures to ensure that any letters mailed to enrolled groups regarding delinquent premiums are not misleading, to ensure compliance with Colorado insurance law.

Issue H2: Failure, in some instances, to include required information in certificates of creditable coverage.

Insurance Regulation 4-2-18, amended effective October 1, 2004, Concerning The Method Of Crediting And Certifying Creditable Coverage For Pre-Existing Conditions, promulgated under the authority granted in Sections 10-1-109(1), 10-16-109 and 10-16-118(1)(b), C.R.S.

Section 4. Definitions

A. "Significant break in coverage" means a period of consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage. For plans subject to the jurisdiction of the Colorado Division of Insurance, a significant break in coverage consists of more than ninety (90) consecutive days. For all other plans (i.e., those not subject to the jurisdiction of the Colorado Division of Insurance), a significant break in coverage may consist of as few as sixty-three (63) days.

Section 5. Rules

B. Colorado law concerning creditable coverage.

4. Certifying creditable coverage

Colorado law does not require a specific format for certificates of creditable coverage as long as all of the information required by 45 C.F.R. 146.115(a)(3) or 45 C.F.R. 148.124(b)(2), as appropriate, is included. However, *any health coverage plan subject to the jurisdiction of the Colorado Division of Insurance must issue certificates of creditable coverage that reflect the definition of "Significant break in coverage" found in Section 4.A. of this regulation*. [Emphasis added.]

INDIVIDUAL CANCELLED FILE SAMPLE – Certificates of Creditable Coverage

Population	Sample Size	Number of Exceptions	Percentage to Sample
275	45	14	31%

SMALL GROUP CANCELLED FILE SAMPLE – Certificates of Creditable Coverage

Population	Sample Size	Number of Exceptions	Percentage to Sample
496	50	7	14%

The examiners reviewed a randomly selected sample of fifty (50) files from a population of 275 HMO individual policies cancelled/nonrenewed/rescinded during the examination period of January 1, 2004 to December 31, 2004. Based on the files examined, it appears that all fourteen (14) of the files with termination dates after October 1, 2004, the Company is not in compliance with Colorado insurance law in that the certificates of creditable coverage that were issued that did not reflect the definition of "Significant break in coverage" required by Regulation 4-2-18(5)(B)(4).

The examiners also reviewed a randomly selected sample of fifty (50) files from a population of 496 HMO small group policies cancelled/nonrenewed/rescinded during the examination period of January 1, 2004 to December 31, 2004. Based on the files examined, it appears that in seven (7) files, the Company is not in compliance with Colorado insurance law in that the certificates of creditable coverage that were issued after October 1, 2004 did not reflect the definition of "Significant break in coverage" required by Regulation 4-2-18(5)(B)(4).

Recommendation No. 13:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-18. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that any required language, including that of a significant break in coverage, is included in all certificates of creditable coverage issued as required by Colorado insurance law.

Issue H3: Failure to use policies and procedures in individual plan cancellations that do not permit unfair discrimination.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (b) False information and advertising generally: Making, publishing, disseminating, circulating, or placing before the public, or causing, directly or indirectly, to be made, published, disseminated, circulated, or placed before the public in a newspaper, magazine, or other publication, or in the form of a notice, circular, pamphlet, letter, or poster, or over any radio or television station, or in any other way, an advertisement, announcement, or statement containing any assertion, representation, or statement with respect to the business of insurance, or with respect to any person in the conduct of his insurance business, which is untrue, deceptive, or misleading;
>
> (f) (II) Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

CANCELLED INDIVIDUAL FILE SAMPLE – Late Terminations Request

Population	Sample Size	Number of Exceptions	Percentage to Sample
275	45	11	24%

The examiners reviewed a randomly selected sample of forty-five (45) files from a population of 275 HMO individual policies cancelled/nonrenewed/rescinded during the examination period of January 1, 2004 to December 31, 2004. It appears that the Company is not in compliance with Colorado insurance law in that its procedures regarding the handling of late termination requests are misleading and allow for unfair discrimination. The Company's termination policies and procedures state that retro terminations may be granted if requested by the member and agreed to by the Company. This could lead to unfair discrimination in that there are no specific guidelines regarding which types of requests should be granted and which shouldn't. Therefore, the decisions could be made inconsistently/arbitrarily, leading to unfair discrimination. Additionally, the policy is misleading in that if a specific date is requested, the policy says the date will be the date the termination form was received but this contradicts all of the sample letters provided as well as the files reviewed.

The Company's procedures "Terminations – Group and Subscriber/Member of Groups" state the following:

> POLICY: In compliance with HB1353, RMHP will not allow retro terminations.
>
> Member Policy: Termination notification must be received by RMHP no later than 5:00 p.m. Mountain Time on the first business day of the month following the disenrollment effective date. Notification received by Rocky Mountain Health Plans later than the first business day of the month following the disenrollment effective date will result in an extension of coverage for an additional month with the required premium.

The Group and Individual Terminations Policies and Procedures state the following (the policy contains no form number or revision date):

> 3. The incoming date stamp on the form determines the date of termination. Example: Termination form that is date stamped 1/06/03 would be terminated as of 1/31/03. Deadline for the termination form is the end of the day of the first business day of the month. Any termination form received after the deadline will be considered a late termination.
>
> 4. If the entire group is terminating due to replacement of their coverage with another carrier then a retro termination can be done provided the group signs an agreement to be responsible for any claims currently submitted or submitted in the future.
>   a. Request proof of replacement coverage.
>   b. Send claims agreement to group for signature.
>   c. Retro term group. Do not bill premiums for the month.
>
> 5. Send Late Termination Letter.doc to the group if the termination date indicated on the form is for a month prior to the end of the current month.
>
> **Solo/Individual Terminations:**
> Solo/Individual Terminations will work the same as group terminations unless there is a particular date indicated on the termination form, if this is the case the termination date will be the date we received the termination form and premiums will be pro-rated in Billing.

The Company's "Late Termination Letter.doc" states the following:

Rocky Mountain Health plans (RMHP) is in receipt of your termination form received <<TermReceivedDate>> for <<MemberName>> to be effective <<RequestedDate>>.

> In accordance with Colorado law (House Bill 02-1353), employers who sponsor health plans are obligated to pay additional premium when the group fails to provide timely notice to carriers. Consistent with the premium payment provisions of our contractwith <<Company>>, Rocky Mountain Health Plans requires notice of terminations by the end of the first business day following the termination effective date.

> Due to the late notification of your termination request, coverage for <<MemberName>> will be extended through <<Newtermdate>> and premium for the additional month(s) will be owed at the same coverage level as <<PreviousMonth>> for this subscriber.

The Company's letter number "EB02R0204" (no identifying title or subject) states the following:

> Rocky Mountain Health Plan (RMHP) has carefully considered your request for credit regarding <<Member Name>>.
>
> Your request has been denied, because RMHP policy is that we do not retro terminate members from coverage. Since we were not notified prior to <<NotnotifiedpriortoDate>> and therefore may have verified this member's eligibility for health care services, RMHP is obligated by law to pay for any health care services <<MemberName>> may have received in <<Month>>.

A review of the files showed that in eight (8) instances where either a mid-month or a retro termination was requested, the Company did not grant any of these requests. There was no explanation in any of the files regarding why the requests were rejected. However, in three (3) cases where the company received a not-sufficient funds or similar notice from a members bank, those members were terminated mid-month, without prior notification to the member of the termination.

Recommendation No. 14:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-3-1104, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its cancellation/ termination procedures to ensure that unfair discrimination is not permitted as required by Colorado insurance law.

CLAIMS
FINDINGS

Issue J1: Failure, in some instances, to pay, deny, or settle claims within the time frames required by Colorado insurance law.

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the carrier's standard claim form with all required fields completed with correct and complete information in accordance with the carrier's published filing requirements. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (a) *Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.*[Emphasis added.]
>
> (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of the additional information is needed to resolve the claim, including any additional medical or other information related to the claim…
>
> (c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

ELECTRONIC CLAIMS PROCESSED OVER 30 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
23,170*	100	77	77%

(*6% of all paid and denied claims)

The examiners reviewed a randomly selected sample of 100 electronic claims from a total summarized population of 23,170 claims that had not been paid, denied or settled within thirty (30) days. It appears the Company is not in compliance with Colorado law in that:

Seventy-seven (77) of the electronic claims in the sample appear to represent clean claims but were not paid, denied, or settled within thirty (30) days, and

PAPER CLAIMS PROCESSED OVER 45 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Sample
8,425*	100	61	61%

(*2% of all paid and denied claims)

The examiners reviewed a randomly selected sample of 100 paper claims from a total summarized population of 8,425 claims that had not been paid, denied or settled within forty-five (45) days. It appears that the Company is not in compliance with Colorado insurance law in that sixty-one (61) of the claims reviewed appear to represent clean claims, but were not paid, denied, or settled within forty-five (45) days. The examiners note that many of the claim numbers selected for review represented adjustments made to original claims. In these cases the examiner reviewed the original claim as well as the adjusted claim and the reason for the adjustment. In some instances the examiners determined that the original claim was a clean claim and therefore the adjusted claim did not appear to be properly paid, denied or settled within the required timeframe.

CLAIMS PROCESSED OVER 90 DAYS

Population	Sample Size	Number of Exceptions	Percentage to Population
3,758*	50	33	66%

(*<1% of all paid and denied claims)

Using ACL™ software, the examiners identified a total of 3,758 claims paid, denied or settled in excess of ninety (90) days from a population of 291,072 claims submitted to the Company during the examination period. A random sample of fifty (50) claims was selected for review from the 3,758 claims paid, denied or settled in excess of ninety (90) days.

It appears the Company is not in compliance with Colorado insurance law in that it failed to pay, deny or settle thirty-three (33) of the reviewed claims within the required ninety (90) days. Absent fraud, all claims are to be paid, denied, or settled within ninety (90) days of receipt.

Recommendation No. 15:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that all claims are paid, denied, or settled within the time frames required by Colorado insurance law.

Issue J2: Failure, in some instances, to pay interest and/or penalty on claims not processed within the time frames required by law.

Section 10-16-106.5, C.R.S., Prompt payment of claims-legislative declaration, states in part:

> (4) (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.
>
> . . . .
>
> (c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.
>
> . . . .
>
> (5) (a) *A carrier that fails to pay, deny or settle a clean claim in accordance with paragraph (a) of subsection (4) of this section or take other required action within the time periods set forth in paragraph (b) of subsection (4) of this section shall be liable for the covered benefit and, in addition, shall pay to the insured or health care provider, with proper assignment, interest at the rate of ten percent annually on the total amount ultimately allowed on the claim, accruing from the date payment was due pursuant to subsection (4) of this section.* [Emphasis added.]
>
> (b) *A carrier that fails to pay, deny, or settle a claim in accordance with subsection (4) of this section within ninety days after receiving the claim shall pay to the insured or health care provider, with proper assignment, a penalty in an amount equal to ten percent of the total amount ultimately allowed on the claim. Such penalty shall be imposed on the ninety-first day after receipt of the claim by the carrier.* [Emphasis added.]

CLEAN CLAIMS PROCESSED OVER 30 DAYS
PAYMENT OF INTEREST

Population	Sample Size	Number of Exceptions	Percentage to Sample
23,170*	100	24	24%

(*6% of all paid and denied claims)

The examiners reviewed a randomly selected sample of 100 electronic claims from a total summarized population of 23,170 claims that had not been paid, denied or settled within thirty (30) days. It appears that the Company is not in compliance with Colorado insurance law in that it failed to pay interest on twenty-four (24) electronic claims that were not adjudicated within the required time-frames. The twenty-four (24) claims identified appeared to be clean claims that required payment of interest and it did not appear that these monies were paid to either the provider or, in the case of incorrect co-pay/co-insurance being collected by the Company, to the insured.

CLEAN CLAIMS PROCESSED OVER 45 DAYS—PAYMENT OF INTEREST

Population	Sample Size	Number of Exceptions	Percentage to Sample
8,425*	100	53	53%

(*2% of all paid and denied claims)

The examiners reviewed a randomly selected sample of 100 paper claims from a total summarized population of 8,425 claims that had not been paid, denied or settled within forty-five (45) days. It appears that the Company is not in compliance with Colorado insurance law in that of the fifty-three (53) paper claims that were not paid, denied, or settled within forty-five (45) days:

- Thirty-three (33) claims appeared to be clean claims, but no interest was paid; and
- Twenty (20) claims appeared to be clean claims but the amount of interest paid was incorrect.

CLAIMS OVER 90 DAYS—PAYMENT OF PENALTY

Population	Sample Size	Number of Exceptions	Percentage to Sample
3,758*	50	45	90%

(*<1% of all paid and denied claims)

The examiners reviewed a randomly selected sample of fifty (50) claims from a total summarized population of 3,758 claims that had not been paid, denied or settled within ninety (90) days. It appears that the Company is not in compliance with Colorado insurance law in that the Company failed to pay a ten (10) percent penalty of the total amount ultimately allowed on the claim to the insured or health care provider on the ninety-first (91st) day on each of the forty-five (45) claims not paid or settled within ninety (90) days.

The examiners note that many of the claim numbers selected for review represented adjustments made to original claims. In these cases the examiner reviewed the original claim as well as the adjusted claim and the reason for the adjustment. In some instances the examiners determined that the original claim was a clean claim and therefore the adjusted claim did not appear to be properly paid, denied or settled within the required timeframe and interest was due.

Additionally, it appears that in many instances the claim reviewed had been updated by a Company representative to show a different "interest clean" date. The examiners were unable to locate documentation to substantiate these updated dates. The dates do not appear to correspond to any particular event or the date the claim was ultimately processed and paid. It does not appear that the Company's staff is applying the above-cited procedure consistently or appropriately, resulting in inaccurate interest payments and a possible violation of Colorado insurance law.

Recommendation No. 16:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Section 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that interest and/or penalty is paid on those claims not processed within the required time frames as required by Colorado insurance law. The Company should also be required to perform a self-audit to identify and pay any interest and/or penalties due on all claims that were not paid or settled within the required time periods from January 1, 2004 through the date of the Final Agency Order.

Issue J3: Failure, in some instances, to pay eligible charges or to request the additional information needed to properly adjudicate the claims.

Section 10-3-1104(1)(f)(II), C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states:

> Making or permitting any unfair discrimination between individuals of the same class or between neighborhoods within a municipality and of essentially the same hazard in the amount of premium, policy fees, or rates charged for any policy or contract of insurance, or in the benefits payable thereunder, or in any of the terms or conditions of such contract, or in any other manner whatever;

Section 10-16-106.5, C.R.S., Prompt payment of claims – legislative declaration, states in part:

> (2) As used in this section, "clean claim" means a claim for payment of health care expenses that is submitted to a carrier on the uniform claim form adopted pursuant to section 10-16-106.3 with all required fields completed with correct and complete information, including all required documents. A claim requiring additional information shall not be considered a clean claim and shall be paid, denied, or settled as set forth in paragraph (b) of subsection (4) of the section. "Clean claim" does not include a claim for payment of expenses incurred during a period of time for which premiums are delinquent, except to the extent otherwise required by law.
>
> (4) (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process.

DENIED CLAIMS SAMPLE

Population	Sample Size	Number of Exceptions	Percentage to Sample
44,856	100	14	14%

From a population of 44,856 denied claims received from January 1, 2004, through December 31, 2004, a randomly selected a sample of 100 denied claims was reviewed.

It appears that the Company is not in compliance with Colorado insurance law in that at the time the claims were denied, it appears that the Company either:

- was in possession of the information it needed to properly adjudicate the claims; or
- it failed to request required additional information.

It appears that this resulted in unfair and inconsistent treatment of members as follows:

- One (1) claim (Comment J4) was incorrectly denied for other insurance;
- One (1) claim (Comment J6) was improperly denied due to an inappropriate modifier;
- Four (4) claims (Comment J8) were incorrectly denied for pre-existing conditions; and
- Eight (8) claims (Comment J11) were incorrectly denied for third party liability.

Recommendation No. 17:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104 and 10-16-106.5, C.R.S. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has reviewed and modified its quality controls to ensure that its processing staff is properly trained to make appropriate decisions and thus avoid denying eligible claims to assure compliance with Colorado insurance law.

Issue J4: Failure to use claim payment procedures that do not result in unnecessary delays.

Section 10-3-1104, C.R.S., Unfair methods of competition and unfair or deceptive acts or practices, states in part:

> (1) The following are defined as unfair methods of competition and unfair or deceptive acts or practices in the business of insurance:
>
> (h) Unfair claim settlement practices: Committing or performing, either in willful violation of this part 11 or with such frequency as to indicate a tendency to engage in a general business practice, any of the following:
>
> (III) Failing to adopt and implement reasonable standards for the prompt investigation of claims arising under insurance policies; or
>
> (VI) Not attempting in good faith to effectuate prompt, fair and equitable settlements of claims in which liability has become reasonably clear;

Section 10-16-106.5(4), C.R.S., Prompt payment of claims – legislative declaration, states in part:

> (a) Clean claims shall be paid, denied, or settled within thirty calendar days after receipt by the carrier if submitted electronically and within forty-five calendar days after receipt by the carrier if submitted by any other means.
>
> (b) If the resolution of a claim requires additional information, the carrier shall, within thirty calendar days after receipt of the claim, give the provider, policyholder, insured, or patient, as appropriate, a full explanation in writing of what additional information is needed to resolve the claim, including any additional medical or other information related to the claim. The person receiving a request for such additional information shall submit all additional information requested by the carrier within thirty calendar days after receipt of such request. Notwithstanding any provision of an indemnity policy to the contrary, the carrier may deny a claim if a provider receives a request for additional information and fails to timely submit additional information requested under this paragraph (b), subject to resubmittal of the claim or the appeals process. If such person has provided all such information necessary to resolve the claim, the claim shall be paid, denied, or settled by the carrier within the applicable time period set forth in paragraph (c) of this subsection (4).
>
> (c) Absent fraud, all claims except those described in paragraph (a) of this subsection (4) shall be paid, denied, or settled within ninety calendar days after receipt by the carrier.

Regulation 4-2-24, effective February 1, 2003, Concerning Clean Claim Requirements for Health Carriers, and promulgated under the authority of 10-16-106.3(2), 10-16-109, and 10-1-109, Colorado Revised Statutes, states:

Section 6 Additional Information

A. A claim with all required fields completed is not considered "clean" if additional information is needed in order to adjudicate the claim. *Carriers may request additional information only if the carrier's claim liability cannot be determined with the existing information on the claim form and the information requested is likely to allow a determination of liability to be made.* When additional information is required, the carrier shall make *the specific request in writing* within thirty calendar days after receipt of the claim form. *If information is being requested from a party other than the billing provider, the provider shall be notified that additional information is needed to adjudicate the claim.* The specific information requested shall be requested within 30 calendar days after receipt of the claim form and identified for the provider upon request. [Emphases added].

B. *Additional information requested must be related to information in the required fields of the claim forms*, [emphasis added] although the genesis of the request may be from other sources, e.g., if the carrier has other information that indicates the information in a required field is incorrect such as previous claims that indicate the treatment was for work-related injuries when the claim form indicates otherwise. Requests for additional information to determine if the treatment is medically necessary or if a pre-existing condition limitation applies would be related to the fields specifying the services provided.

C. A carrier is not permitted to request additional information for the purpose of determining medical necessity when the claim form has all required fields correctly completed and the services were preauthorized pursuant to 10-16-704(4), C.R.S.

D. *When all additional information or documentation necessary to resolve the claim is provided with the appropriate claim form that includes all required elements as specified in Section 5 of this regulation, the claim shall be considered a clean claim and processed within the timeframes specified in statute.* [Emphasis added.] The following circumstances are those for which additional information is generally required by most health carriers:

   i. When the coverage is not primary, an EOB from the primary payer;
   ii. When service/procedure codes indicate "unusual" procedural services or anesthesia, the medical records to justify medical necessity;
   iii. When surgical procedures utilize multiple surgeons, the medical records to justify medical necessity;
   iv. When the procedure is a repeat procedure, the medical records to justify medical necessity;
   v. When supplies and materials are ordered on an outpatient basis, the medical records and/or invoice to justify medical necessity or allowable fee; and
   vi. When services are billed using a "by report" or unlisted CPT code, medical records to substantiate the claim.

E. *If a managed care plan requires medical or other records on all claims for particular types of services/procedures or diagnosis codes, the carrier must clearly disclose such requirements in the provider contract, provider manual, or provider manual updates*. [Emphasis added.] If a carrier contracts with an intermediary, the carrier shall be responsible for making sure the intermediary provides such disclosure to contracted providers in a timely manner.

F. When requesting medical records, carriers must identify the particular component(s) of the medical record being requested or indicate the specific reason for the request, e.g., progress reports for most recent three months, or records to establish the medical necessity of the treatment provided. The records requested must be related to the service/procedure of the claim and limited to the minimum amount of information necessary. Requests for "all medical records" is not specific enough and would not be an appropriate request for claim adjudication. Medical information requested from institutional providers shall be additionally limited to the following:

   i. History and physical reports;
   ii. Consultant reports;
   iii. "Op" reports;
   iv. Discharge summaries;
   v. Emergency department reports;
   vi. Diagnostic reports; and
   vii. Progress reports.

The Company's Claim Medical Processing Manual – Third Party Processing, revised March of 2005, states on page 4:

> Third Party Liability (TPL) injury information that relates to claims that fit the TPL criteria is stored in the Rocky Interface database. *All claims that meet TPL criteria will pend for possible Third Party Liability Review.* [Emphasis added].

On page 7:

> **Financial Recovery List of Diagnosis Codes**
>
> The diagnosis lists are configured for the RMHP Financial Recovery Team to research claims for potential third party liability.
>
> Effective 04/05/04: TPL Diagnosis List *
>
> *Examiner Note – this is a hyperlink to an Excel spreadsheet containing 1173 diagnosis codes.

On page 24:

> **TPL Investigation**

The TPL Team investigates claims using criteria related to the TPL diagnosis, dollar amount or known Third Party Liability. Warning messages and member notes are set up so that the Claims Examiner will be made aware of when these claims should be pended.

Investigation Process

- One *phone call* should be made to the member. [Emphasis added].
- If the member does not respond, a letter will be sent within 48 hours after the initial message was left.
- Written request for information shall be mailed within 30 days of the date the claim was submitted.
- The letter should request that the information be returned within two weeks from the date the letter was generated. Claims will not be denied R61 until 30 days after the letter was generated.
- Commercial, Individual, and Medicaid: If the member does not respond by 30 days, related claims will be process using R61 claim denied because

On page 28:

COB/TPL Macess & Facets Workflow

TP32 Workflow

The TPL Interface (pre-Facets) assigns pend code TP32 when the following occurs:

- The billed diagnosis has been defined within configuration (A warning message may be attached that states ***Possible Third Party/Pend if line item is great than $300.00***.)

On page 38:

TP60 Workflow

Review all claims aged 30 days or greater, from the date the letter was sent, by comparing information in the TPL interface to the diagnosis on the claim. Once this is complete claims need to be denied, pended or paid in Facets.

TPL Interface

- If the information is complete the notes will state this or the type of injury will state "No COB". The pend reason CB60 should be noted in the memo field of the claim.
- If the injury\illness is still in the research process, meaning a letter has been sent but 30 days have not passed or the claim has not aged 80 days, the claim should remain in TP60. If the 30 days have passed or the claim is older than 80 days the claim should be denied allowing $0.00 and using the explanation code R61.

On page 46:

RMHP – PRIMARY FOR ALL LOB

Line of Business	Scenario	Worker's Comp	Auto and No Fault	Auto and Tort System	Liability – Homeowners	Liability – Med Pay

Private Pay	Information in database, notes indicate Other Party Primary	Deny Claim – R63	Deny Claim – R62	Med-pay or underinsured/ uninsured motorist available deny R62: Otherwise Pay Claim & Pursue	Pay Claim & Pursue	Pay Claim & Pursue
Private Pay	No information in database, notes don't indicate Other Party Primary. Send letter to member, if no response within 30 days	Deny Claim No Injury Information Received – R61	Deny Claim No Injury Information Received – R61	Deny Claim No Injury Information Received – R61	Deny Claim No Injury Information Received – R61	Deny Claim No Injury Information Received – R61

The form letter (no document number or revision date available for this form) used by the Company to investigate third party liability claims states on page 1:

> …To help keep health care premiums down, we research claims to find out if another insurance carrier or a person or a business may be responsible for payment. This research also helps you get the medical coverage your plan provides as soon as possible.
>
> Please answer **all** the questions below. Write with **BLACK INK** only. Then return this letter in the enclosed envelope **within 20 days of the date of this letter**. Without this information, payment of these claims could be *delayed, or you may have to pay for the cost of the care yourself.* [Emphasis added].
>
> Date of original accident/injury/illness: _____
>
> Was the injury the result of any illness? YES NO
>
> Was the injury the result of any accident? YES NO
>
> Was the injury the result of an automobile accident? YES NO
> If yes, please provide RMHP with a complete copy of your auto policy.
>
> Was the injury the result of loading/unloading/exiting or entering vehicle? YES NO
> If yes, please provide RMHP with a complete copy of your auto policy.
>
> Was the injury the result of maintenance on your vehicle? YES NO
> If yes, please provide RMHP with a complete copy of your auto policy.

Was or does your work contribute to your condition? YES NO

The examiners reviewed the Company's Third Party Liability claim handling procedures. Adherence to these procedures may result in a violation(s) of Colorado insurance law. These procedures require that additional information be requested on all claims over a certain dollar amount and containing certain diagnosis codes. It appears that the Company is ignoring the accident information fields on the initial claim form and instead requesting the information again via the above-cited TPL form letter. Requests for additional information to determine liability should be specific to the information necessary for the Company to determine its liability, and should not include questions regarding unrelated information or information already provided on the provider's claim form. Also, it appears that the mailing of this letter is preceded by a phone call to the member. All requests for additional information necessary to process a claim must occur in writing. It appears that application of these procedures may result in unnecessary claim payment delays.

Recommendation No. 18:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Sections 10-3-1104 and 10-16-106.5, C.R.S. and Regulation 4-2-24. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its claim payment procedures to limit requests for additional information to only those instances in which additional information is necessary for the Company to determine its liability, to ensure compliance with Colorado insurance law.

UTILIZATION REVIEW FINDINGS

Issue K1: Failure, in some instances, to include all required elements in written notification letters sent to members and providers regarding appeals.

Regulation 4-2-17(VIII), amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, Appeals of Adverse Determinations, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b), and 10-16-109, C.R.S., states in part:

I. Standard Appeals

A. First Level Appeal Review

3. For standard appeals the health carrier shall notify in writing both the covered person and the attending or ordering provider of the decision within twenty (20) working days following the request for an appeal. *The written decision shall contain* [emphasis added]:

a. The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For purposes of the section, the physician and the consulting clinical peers shall be called "the reviewers");

e. A description of the process for submitting a grievance in writing requesting a further, second level appeal review of the case.

Regulation 4-2-17, amended effective April 1, 2004, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 10. First Level Review

E. (1) First level reviews shall be evaluated by a physician who shall consult with an appropriate clinical peer or peers, unless the reviewing physician is a clinical peer. The physician and clinical peer(s) shall not have been involved in the initial adverse determination. However, a person that was previously involved with the denial may answer questions.

I. The decision issued pursuant to Subsection G shall set forth in a manner calculated to be understood by the covered person:

(1) The name, title The name, title and qualifying credentials of the physician evaluating the appeal, and the qualifying credentials of the clinical peer(s) with whom the physician consults. (For the purposes of this section, the physician and consulting clinical peers shall be called "the reviewers.");

J. A first level review decision involving an adverse determination issued pursuant to Subsection G shall include, in addition to the requirements of Subsection I.

LEVEL 1 APPEALS – Reviewer's Credentials

Population	Sample Size	Number of Exceptions	Percentage to Sample
38	38	34	90%

LEVEL 1 APPEALS – Peer's Credentials

Population	Sample Size	Number of Exceptions	Percentage to Sample
38	38	28	74%

The examiners reviewed the entire population of thirty-eight (38) HMO utilization review first level appeals files requested during the examination period of January 1, 2004 to December 31, 2004. Eleven (11) of the files contained appeal requests that were received prior to April 1, 2004 and therefore were subject to the April 1, 2000 version of amended Regulation 4-2-17. It appears that the Company did not meet the requirements of Colorado insurance law in that in its written determination notices sent to the provider and the member did not contain all required elements.

- In thirty-four (34) of the files, the name, title, and/or credentials of the physician evaluating the appeal were not documented on the written notifications; and

- In twenty-eight (28) of the files, the credentials of the clinical peer(s), with whom the evaluating physician consulted, were not documented on the written notification.

Recommendation No. 19:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that its written notification letters regarding appeals, contain all elements as required by Colorado insurance law.

Issue K2: Failure, in some instances, to make utilization review approval determinations or to notify the member and provider of the determination in the manner and time frame allowed by Colorado insurance law.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated under the authority of Sections 10-1-109, 10-3-1110, 10-16-113(3)(b) and 10-16-109, C.R.S., states in part:

Section 6. Procedures for Review Decisions

B. For prospective review determinations, a health carrier shall make the determination within two (2) working days of obtaining all necessary information regarding a proposed admission, referral, procedure or service requiring a review determination.

1) In the case of a determination to certify an admission, procedure or service, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the initial certification; and shall provide written or electronic confirmation of the telephone notification to the covered person and/or the provider within two (2) working days of making the initial certification

C 1) For concurrent review determinations, a health carrier shall make the determination within one (1) working day of obtaining all necessary information.

2) In the case of a determination to certify an extended stay or additional services, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the certification; and shall provide written or electronic confirmation to the covered person and/or the provider within one (1) working day after the telephone notification. The written or electronic notification shall include the number of extended days or next review date, the new total number of days or services approved, and the date of admission or initiation of services.

D. For retrospective review determinations, a health carrier shall make the determination within thirty (30) working days of receiving all necessary information.

1) In the case of a certification, the carrier shall notify in writing the covered person and the provider rendering the service within five (5) working days of making the determination to provide coverage.

Regulation 4-2-17, amended effective April 1, 2004, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

> Section 6. Standard Utilization Review
>
> A A health carrier shall maintain written procedures pursuant to this section for making utilization review decisions and for notifying covered persons of its decisions. For purposes of this section, "covered person" includes the designated representative of a covered person.
>
> B. (1) (a) (i) Subject to Subparagraph (b) of this paragraph, for prospective review determinations, a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the health carrier receives the request.
>
> C. (1) (a) For retrospective review determinations, a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination within a reasonable period of time, but in no event later than thirty (30) days after the date of receiving the benefit request.

UR APPROVALS – Phone Notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,609	100	15	15%

UR APPROVALS – Written Notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,609	100	14	14%

UR APPROVALS – Notification

Population	Sample Size	Number of Exceptions	Percentage to Sample
5,609	100	23	23%

The examiners reviewed a randomly selected sample of 100 files from a population of 5,609 HMO utilization review (UR) approvals requested during the examination period of January 1, 2004 to December 31, 2004. Twenty-two (22) of the files contained UR requests that occurred prior to April 1, 2004 and therefore were subject to the April 1, 2000 version of Regulation 4-2-17. It appears that the Company did not meet the requirements of Colorado insurance law in that:

- In fifteen (15) of the files with request dates prior to April 1, 2004, phone notification was not provided;
- In fourteen (14) of the files with request dates prior to April 1, 2004, written notice was not provided; and

- In twenty-three (23) of the files with request dates on or after April 1, 2004, the provider and the covered person were not notified of the determination.

Recommendation No. 20:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its utilization review approval procedures to ensure that utilization review determinations are made and communicated in the proper manner and within the time frame required to ensure compliance with Colorado insurance law.

Issue K3: Failure, in some instances, to provide written notification of adverse utilization review denials or to provide the notifications within the time frames required by Colorado insurance law.

Regulation 4-2-17, amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b), and 10-16-109, C.R.S., states in part:

Section 6. Procedures for Review Decisions

(B) (2) In the case of an adverse determination, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination; and shall provide written or electronic confirmation of the telephone notification to the covered person and the provider within one (1) working day of making the adverse determination.

(C) (3) In the case of an adverse determination, the carrier shall notify by telephone the provider rendering the service within one (1) working day of making the adverse determination; and shall provide written or electronic confirmation to the covered person and the provider within one (1) working day of the telephone notification. The service shall be continued without liability to the covered person until the covered person and the provider rendering the service have been notified of the determination.

(D) (2) In the case of an adverse determination, the carrier shall notify in writing the provider rendering the service and the covered person within five (5) working days of making the adverse determination.

Regulation 4-2-17, amended effective April 1, 2004, Prompt Investigation of Health Plan Claims Involving Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

Section 6. Standard Utilization Review

(B) (1) (a) (i) Subject to Subparagraph (b) of this paragraph, for prospective review determinations, a health carrier shall make the determination and notify the covered person and the covered person's provider of the determination, whether the carrier certifies the provision of the benefit or not, within a reasonable period of time appropriate to the covered person's medical condition, but in no event later than fifteen (15) days after the date the health carrier receives the request.

(ii) Whenever the determination is an adverse determination, the health carrier shall make the notification of the adverse determination in accordance with Subsection E.

(E) (1) A notification of an adverse determination under this section shall, in a manner set calculated to be understood by the covered person, set forth:

(2) A health carrier must provide the notice required under this section in writing, either on paper or electronically.

Section 7. Expedited Utilization Review

(B) (1) (a) For an urgent care request, unless the covered person has failed to provide sufficient information for the health carrier to determine whether, or to what extent, the benefits requested are covered benefits or payable under the health carrier's health benefit plan, the health carrier shall notify the covered person and the covered person's provider of the health carrier's determination with respect to the request, whether or not the determination is an adverse determination, as soon as possible, taking into account the medical condition of the covered person, but in no event later than seventy-two (72) hours after the receipt of the request by the health carrier.

(b) If the health carrier's determination is an adverse determination, the health carrier shall provide notice of the adverse determination in accordance with Subsection E.

(D) For purposes of calculating the time periods within which a determination is required to be made under Subsection B or C, the time period within which the determination is required to be made shall begin on the date the request is filed with the health carrier in accordance with the health carrier's procedures established for filing a request without regard to whether all of the information necessary to make the determination accompanies the filing.

(E) (2) (a) A health carrier may provide the notice required under this section orally, in writing or electronically.

(b) If notice of the adverse determination is provided orally, the health carrier shall provide written or electronic notice of the adverse determination within three (3) days following the oral notification.

UR DENIALS – Written Notification Not Provided

Population	Sample Size	Number of Exceptions	Percentage to Sample
453	50	7	14%

The examiners reviewed a randomly selected sample of fifty (50) out of a population of ninety-six (96) HMO utilization review denial files requested during the examination period of January 1, 2004 to December 31, 2004. Eleven (11) of the files contained UR request dates prior to April 1, 2004 and therefore these files were subject to the April 1, 2000 version of the regulation. It appears that the Company did not meet the requirements of Colorado insurance law in that:

- In one (1) of the files with a request date prior to April 1, 2004, no written notification was provided;

- In two (2) of the files with request dates prior to April 1, 2004, the written notification was not sent to both the member and provider;

- In two (2) of the files with request dates on or after April 1, 2004, the written notification was not sent to both the member and provider; and

- In two (2) of the files with request dates on or after April 1, 2004, the written notification was not sent with in the required timeframe.

Recommendation No. 21:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that written notifications of utilization review denials are sent within the appropriate time frame to all mandated individuals as required by Colorado insurance law.

Issue K4: Failure, in some instances, to include all required elements in written notifications of utilization review denials sent to members and providers.

Regulation 4-2-17(VI), amended effective April 1, 2000, Prompt Investigation of Health Plan Claims Involving Utilization Review, Procedures For Review Decisions, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(3)(b), and 10-16-109, C.R.S., states in part:

> E. *A written notification of an adverse determination shall include* the principal reasons for the determination, the *instructions for initiating an appeal* or reconsideration of the determination, *including expedited appeals*, and the *instructions for requesting a written statement of the clinical rationale, including the clinical criteria used to make the determination*, to any party who received notice of the adverse determination and who follows the procedures for a request. *A carrier shall specify that such an appeal process shall include a two-level internal review*, except as provided for in section 8.I.A.5 of this regulation. [Emphases added.]

Regulation 4-2-17(VI), amended effective April 1, 2004, Prompt Investigation of Health Plan Claims Involving Utilization Review, Standard Utilization Review, promulgated pursuant to Sections 10-1-109, 10-3-1110, 10-16-113(2) and (3)(b), and 10-16-109, C.R.S., states in part:

> E. (1) A notification of an adverse determination under this section shall, in a manner calculated to be understood by the covered person, set forth:
>
> (a) An explanation of the specific medical basis for the adverse determination;
>
> (b) The specific reason or reasons for the adverse determination;
>
> (c) Reference to the specific plan provisions on which the determination is based;
>
> (d) A description of any additional material or information necessary for the covered person to perfect the benefit request, including an explanation of why the material or information is necessary to perfect the request;
>
> (e) *If the health carrier relied upon an internal rule, guideline, protocol or other similar criterion to make the adverse determination, either the specific rule, guideline, protocol or other similar criterion or a statement that a specific rule, guideline, protocol or other similar criterion was relied upon to make the adverse determination and that a copy of the rule, guideline, protocol or other similar criterion will be provided free of charge to the covered person upon request;* [Emphasis added.]
>
> (f) If the adverse determination is based on a medical necessity or experimental or investigational treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for

making the determination, applying the terms of the health benefit plan to the covered person's medical circumstances or a statement that an explanation will be provided to the covered person free of charge upon request;

(g) *If applicable, instructions for requesting:*

(i) A copy of the rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, as provided in Subparagraph (e) of this paragraph; or

(ii) The written statement of the scientific or clinical rationale for the adverse determination, as provided in Subparagraph (f) of this paragraph; and [Emphasis added.]

(h) *A description of the health coverage plan's review procedures and the time limits applicable to such procedures and shall advise the covered person of the right to appeal such decision;* [Emphasis added.]

(2) *A health carrier must provide the notice required under this section in writing, either on paper or electronically.* [Emphasis added.]

UR DENIALS – Written Notice Information

Population	Sample Size	Number of Exceptions	Percentage to Sample
96	50	17	34%

The examiners reviewed a randomly selected sample of fifty (50) out of a population of ninety-six (96) HMO utilization review denial files requested during the examination period of January 1, 2004 to December 31, 2004. Eleven (11) of the files contained UR request dates prior to April 1, 2004 and therefore these files were subject to the April 1, 2000 version of the regulation. It appears that the Company did not meet the requirements of Colorado insurance law in that its written determination notices sent to the member and/or provider did not include all required items.

- In five (5) of the eleven (11) files subject to the April 1, 2000 version of the regulation, the written notification did not include information on the two-level internal appeals process;
- In two (2) of the eleven (11) files subject to the April 1, 2000 version of the regulation, the written notice did not include expedited appeal instructions;
- In six (6) of the files the written notice did not include the instructions for requesting the protocol or clinical rationale used in making the determination; and
- In four (4) of the files the written notice did not include instructions on how to request the internal guidelines or similar criteria used in making the determination.

Recommendation No. 22:

Within thirty (30) days, the Company should provide documentation demonstrating why it should not be considered in violation of Amended Regulation 4-2-17. In the event the Company is unable to show such proof, it should provide evidence to the Division of Insurance that it has revised its procedures to ensure that written notification of utilization review denials include all necessary elements as required by Colorado insurance law.

SUMMARY OF ISSUES AND RECOMMENDATIONS

State Market Conduct Examiners

Jeffory A. Olson, CIE, FLMI, AIRC, ALHC
David M. Tucker, AIE, FLMI, ACS
John E. Bell
Amy N. Gabert
Paula M. Sisneros, AIS

For

The Colorado Division of Insurance
1560 Broadway, Suite 850
Denver, Colorado 80202

participated in this examination and in the preparation of this report.